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IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1084

JACK B. KREMENS, et al., *Appellants,*

v.

KEVIN BARTLEY, et al., *Appellees.*

On Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

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BRIEF FOR THE PLAINTIFFS IN POE, ET AL. v. MATHEWS, ET AL. (D.D.C. NO. 74-1800); J. L. ET AL. v. PARHAM, ET AL. (M.D. GA. NO. 75-163-MAC), APPEAL DOCKETED (NO. 75-1690, MAY 21, 1976); MARTIN M., ET AL. v. SHEPHARD, ET AL. (D. CONN. NO. H-75-130); AND D. L. K., ET AL. v. STUBBS, ET AL. (S.D. MISS. NO. J76-3(C)) AS AMICI CURIAE

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BRIEF FOR THE PLAINTIFFS IN POE, ET AL. v. MATHEWS, ET AL. (D.D.C. NO. 74-1800); J. L., ET AL. v. PARHAM, ET AL. (M.D. GA. NO. 75-163-MAC), APPEAL DOCKETED (NO. 75-1690, MAY 21, 1976); MARTIN M., ET AL. v. SHEPHARD, ET AL. (D. CONN. NO. H-75-130); AND D. L. K., ET AL. v. STUBBS, ET AL. (S.D. MISS. NO. J76-8(C)) AS AMICI CURIAE

This brief amici curiae is filed by the plaintiffs in *Poe, et al.* v. *Mathews, et al.* (D.D.C. No. 74-1800); *J.L., et al.* v. *Parham, et al.*, 412 F. Supp. 112 (M.D. Ga. 1976), *appeal docketed*, No. 75-1690 (May 21, 1976); *Martin M., et al.* v. *Shephard, et al.* (D. Conn. No. H-75-130; and *D.L.K., et al.* v. *Stubbs, et al.* (S.D. Miss. No. J76-8(C)), with the consent of the parties herein, in accordance with Rule 42 of the Rules of this Court.

INTEREST OF THE AMICI CURIAE

Amici are children who were committed to state mental institutions by their parents or custodians without

being afforded the right to an evidentiary hearing. They are the plaintiffs in four cases pending in the lower federal courts, or on appeal to this Court, which challenge the procedures by which they were committed; that is, whether a state can commit a child to a mental institution without affording him an evidentiary hearing upon the consent of the child's parents, guardian or custodian.[1]

This brief is filed because the issues involved in this appeal overlap those presented in the cases in which amici are plaintiffs, and the resolution of these issues

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[1] Plaintiff in *Poe* v. *Mathews, supra,* represent a class of "persons under the age of 18 years who have been committed to St. Elizabeths Hospital against their will at the request of their parents or guardians pursuant to D.C. CODE §§ 21-511 and 512." Order, March 25, 1975. Proceedings in *Poe* have been stayed pending this Court's decision in the instant case. Order, March 5, 1976.

Plaintiffs in *J.L.* v. *Parham, supra,* represent persons younger than 18 years of age who have been detained at mental institutions within the state of Georgia pursuant to GA. CODE ANN. § 88.503.1. On February 26, 1976, the United States District Court for the Middle District of Georgia held that statute to be unconstitutional on the ground that it did not provide juveniles with hearing rights and entered appropriate relief. 412 F. Supp. at 139-40. The order of the three-judge court was stayed by this Court on April 5, 1976. 425 U.S. ——, 96 S. Ct. 1503. An appeal from the district court's decision was docketed on May 21, 1976.

Plaintiffs in *Martin M.* v. *Shephard, supra,* represent persons under the age of 16 years who are or may be confined against their will at the request of their parents or guardians at any state mental institution pursuant to CONN. GEN. STAT. § 17-187 as limited by § 17-206a(d). Order, Dec. 5, 1975. The case is in the discovery stage.

Plaintiffs in *D.L.K.* v. *STUBBS, supra,* are unmarried persons under the age of 18 years who have been committed to Mississippi mental institutions against their will at the request of their parents or guardians pursuant to MISS. CODE ANN. § 41-21-103-2(c). This case is also in the discovery stage.

in this case may control the decisions in these other cases. Amici argue herein that, because of the revision of Pennsylvania's statutory procedures for the commitment of children that occurred in July, 1976, after the decision of the district court, this appeal should not be decided on the merits. Amici believe that a decision should not be rendered on the merits, because, for reasons set forth below, the statutory changes destroy that "adverse concreteness" which is necessary for the proper and informed decision of important constitutional issues.

In the event that the Court reaches the merits, however, this brief sets forth amici's position with respect to the underlying question of whether due process guarantees a child the right to an evidentiary hearing in connection with civil commitment to a mental institution, despite the consent or acquiescence of his parent or custodian. In the course of this brief, amici will bring to the Court's attention factual material, developed through the discovery process and trial of their respective cases, concerning the impact of mental institutionalization upon children and the operation of juvenile commitment schemes.[2] This additional information will give the Court a broader basis upon which to decide the important constitutional questions raised by this appeal.[3]

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[2] Amici will lodge with the Clerk of this Court the materials cited from the records in their cases shortly after filing this brief.

[3] This brief will not address the question of the procedures required to commit juveniles to facilities for the mentally retarded. Amici were all commiteed to mental institutions on the ground that they were mentally ill, and the cases they have brought challenge only such commitments.

QUESTIONS PRESENTED

1. Does this Court have jurisdiction over the appeal, and if so, should such jurisdiction be exercised in light of the intervening change in the Pennsylvania statutes challenged by appellees?

2. Does the Due Process Clause of the Fourteenth Amendment guarantee a juvenile the right an an evidentiary hearing and access to counsel in connection with his commitment to a mental institution, regardless of the concurrence of his parent or custodian in the commitment decision?

FACTUAL STATEMENT

A. COMMITMENT PROCEDURES IN THE STATES WHERE AMICI ARE CONFINED AND THOSE GENERALLY IN EFFECT

The statutes of every state and the District of Columbia authorize commitment of persons to mental institutions.[4] In most states, and in each of the states in which amici reside, there are two procedures for the commitment of adults. An adult may be committed without a court order if he applies to a mental institution under a voluntary commitment statute.[5] Gen-

[4] For a list of citations to the commitment statutes *see Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-04 nn. 11-14 (1974) and Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 n. 1 (1974).

[5] *See, e.g.*, CONN. GEN. STAT. § 17-187 as modified by § 17-206a (d); D.C. CODE § 21-511 to -512; GA. CODE ANN. § 88-503; MISS. CODE ANN. § 41-21-103. The District of Columbia also permits admission without a hearing when a relative applies for the commitment and the person consents in writing; however, the person must be released immediately upon request. D.C. CODE §§ 21-513 to -514.

erally, the only check on the appropriateness of the commitment is the institution's agreement that the applicant needs treatment. Once committed, however, the individual is free to leave the institution upon request, unless involuntary commitment proceedings are initiated within a specified period after the request.[6]

On the other hand, if the adult does not apply for admission to a mental institution, the state or another third party must petition for an involuntary commitment order.[7] Under the involuntary schemes of virtually all states, including those in which amici reside, an adult cannot be committed without the opportunity to contest the petition in an evidentiary hearing.[8] The timing of the hearing depends on whether or not the individual's condition is alleged to necessitate immediate commitment. If immediate commitment is requested, the commitment is termed an emergency com-

[6] *See* CONN. GEN. STAT. § 17-187 (10 days; if the admission was "informal," he must be released immediately); D.C. CODE § 21-512 (2 days); GA. CODE ANN. § 88-503.3(a) (5 days, not including Saturdays, Sundays and holidays); MISS. CODE ANN. § 41-21-103(3) (5 days, not including Saturdays, Sundays and holidays).

[7] *See, e.g.*, CONN GEN. STAT. §§ 17-177 to -183; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. §§ 88-504 to -508; MISS. CODE ANN. §§ 41-21-61 to -99.

[8] The right to a hearing in these states generally means the right to adequate notice; to counsel, appointed if the individual is indigent; to present evidence and confront and cross-examine witnesses; and to a decision by an impartial tribunal based solely on the evidence adduced at the hearing. *See* CONN. GEN. STAT. §§ 17-177 to -183; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. §§ 88-507 to -508; MISS. CODE ANN. §§ 41-21-73 to -79. Throughout this brief, "evidentiary hearing" is used to refer to a hearing containing these safeguards.

mitment,[9] and the hearing occurs after the person has been institutionalized.[10] In a non-crisis case, the hearing must precede the commitment.[11]

Children are subject to both the voluntary and involuntary commitment schemes. In most states, however, it is the parent or custodian of the juvenile, rather than the child himself, who has the statutory authority to consent or object to commitment. If the parent or custodian objects to institutionalization, an evidentiary hearing is held under the involuntary procedure.[12] But if the parent or custodian applies for or consents to institutionalization, the commitment is considered "voluntary" and is made without a hearing, even over the child's protests.[13] In that circumstance,

[9] Emergency commitment standards frequently require an allegation not only that the person is mentally ill but also that he poses an immediate threat to himself or others. *See* CONN. GEN. STAT. § 17-183 ("suddenly becomes in need of care or treatment in a hospital for mental illness . . . [and] a danger to himself or others"); D.C. CODE § 21-521 ("likely to injure himself or others if not immediately detained"); Laws of 1976, ch. 401 § 2 (to be codified as MISS. CODE ANN. § 41-21-71(2)) ("substantial risk of imminent physical harm to himself . . . or . . . other persons"); *but cf.* GA. CODE ANN. § 88-504.2 ("mentally ill and likely to inqure himself or others").

[10] *See* CONN. GEN. STAT. § 17-183; D.C. CODE §§ 21-521 to -527; GA. CODE ANN. § 88-504; MISS. CODE ANN. §§ 41-21-71 to -83.

[11] *See* CONN. GEN. STAT. § 17-178; D.C. CODE §§ 21-541 to -545; GA. CODE ANN. § 88-507; MISS. CODE ANN. § 41-21-71(2).

[12] *See* statutes cited in note 7, *supra*.

[13] Consent to the juvenile's institutionalization need not be made by a parent or guardian. In Pennsylvania, for example, anyone acting "in loco parentis" may give such consent. 50 PA. STAT. ANN. § 4403(a)(2); *see also* statutes cited in note 3, *supra*. Thus, in the case of a juvenile who is in the custody of the state welfare department, the consenting party may be the state itself. In Connecticut, however, a superior court has held that a juvenile cannot be committed to a state mental institution by the state welfare department without prior judicial approval. *Sims* v. *Arafeh* (No. 24259, June 23, 1975).

the parent or custodian—but not the child—has the power to terminate the commitment.

B. COMMITMENT PROCEDURES IN PENNSYLVANIA

1. The Statutory Procedure When the Suit Was Filed

When the instant case was filed,[14] Pennsylvania commitment procedures paralleled those described above.[15] A person 18 years of age or younger could be committed to an institution for the mentally ill or mentally retarded without an evidentiary hearing if one of his parents, or a person standing in loco parentis to him, signed an application to an institution, and the director of the institution, after examination, agreed that the child was "in need of care or observation." 50 PA. STAT. ANN. § 4403(b).

The named plaintiffs were each committed to Haverford State Hospital, a state mental institution, upon consent of their parents, without an evidentiary hearing, when they were between the ages of fourteen and seventeen. A. 788-89. Plaintiffs filed this suit on behalf of all children committed to facilities for the mentally ill or mentally retarded alleging that the commitment of juveniles without an evidentiary hearing, under the voluntary scheme, 50 PA. STAT. ANN. §§ 4402 and 4403, violates due process.

[14] November 16, 1972. Joint Appendix 1. (Hereafter, "A. ——.")

[15] For the entire Pennsylvania state statutory scheme operative at the time of the lower court's decision, *see* 50 PA. STAT. ANN. §§ 4402-06.

2. The Procedures Under the Regulations Issued Prior to the Judgment Below

On September 1, 1973—after the suit was initiated, but before the trial was held—Pennsylvania's procedures for commitment of juveniles were altered by regulgation. A. 786-788 n. 5. The regulations provide that children 13 years of age or older, who are committed under the "voluntary" procedure, must be informed of their rights within 24 hours, including the right of access to counsel. If such a child objects to his confinement, he must be released within 48 hours, unless a petition for an involuntary commitment is filed within that period. If a petition is filed, the child remains in the institution pending the hearing. The regulations do not set a specific time period in which the hearing must be held. The regulations do not afford any evidentiary hearing rights, or other additional rights, to children less than 13 years old.[16]

3. The Procedures Under the Statute Enacted After the Entry of the Judgment Below

On July 9, 1976, after this Court noted probable jurisdiction of the appeal of the district court's order, the Pennsylvania legislature significantly revised its entire civil commitment law. Act No. 143, S.B. No. 1025. Two changes are of especial importance to this Court's deliberations. First, the new law provides that children

[16] The regulations also provide that a juvenile may be committed to a mental institution only if he is referred to the institution by a "recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency", and the referral is accompanied by a psychiatric evaluation and a report recommending his institutionalization. This is in addition to the pre-existing requirements of parental or custodial consent, and approval of the director of the institution. *Id.*

fourteen years of age or older cannot be voluntarily committed to a mental institution by their parents or guardians. *Id.* § 201. Second, although a child less than fourteen years of age may still be committed by his "parent, guardian, or person standing in loco parentis," (*id.*), "any responsible party" who believes that it would be in the child's interest to be withdrawn from the institution or provided treatment in a less restrictive setting may petition the juvenile division of the court of common pleas for the county of the juvenile's residence. The court must then appoint counsel for the child and conduct a hearing within ten days to determine "what inpatient treatment, if any, is in the minor's best interest." *Id.* § 206(b).[17]

The status of the September 1, 1973 regulations as they pertain to mentally ill youths is unclear. Amici assume they remain in effect insofar as they do not conflict with the new law.

C. THE DECISION BELOW

The three-judge district court, in an opinion dated July 24, 1975, held that the Pennsylvania juvenile commitment statutes, §§ 4402 and 4403, were violative of due process because of their failure to afford children the right to an evidentiary hearing in connection with their confinement in an institution for the mentally ill or the mentally retarded. The court found that the state regulations failed to cure the due process objections to the statutory procedures because (1) the regulations place the burden on the child to contact counsel and to

[17] The new Pennsylvania legislation makes no change in the procedure for the institutionalization of mentally retarded children. *Id.* § 507(a).

object to commitment, (2) they set no limit on the time a child may be confined after his objection and pending a hearing, and (3) the regulations have no applicability to children under thirteen. A. 786-88 n. 5.

The district court issued an injunction requiring that children whose commitment is sought be afforded basic procedural rights, including automatic access to counsel and the right to an evidentiary hearing, which cannot be waived by their parents.[18] Under the court's order, whenever the parent or custodian seeks a child's commitment, independent counsel must be appointed for the child. The child may waive his hearing rights and voluntarily accept institutionalization, but only

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[18] The court required these procedures:

(1) a probable cause hearing before an impartial officer within seventy-two (72) hours from the date of initial detention;

(2) a post-commitment hearing before an impartial hearing officer within two (2) weeks from the date of initial detention;

(3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment;

(4) counsel at all significant stages of the commitment process and, if the child is indigent, appointment of free counsel;

(5) the right of the child to be present at all hearings concerning his proposed commitment;

(6) a finding by clear and convincing proof that the child is in need of institutionalization;

(7) the right of the child to confront and to cross-examine witnesses against him, to offer evidence in his own behalf, and to offer testimony of witnesses.

A. 810-11.

with the approval of his attorney and the hearing officer.[19]

The State of Pennsylvania appealed and moved this Court for a stay of the district court's order. The stay was granted on December 16, 1975. 423 U.S. 1028. Probable jurisdiction was noted on March 22, 1976. 424 U.S. ——, 96 S. Ct. 1457.

SUMMARY OF ARGUMENT

The Court should not reach the merits of this appeal because of the enactment of Act No. 143, S.B. 1025 by the State of Pennsylvania on July 9, 1976. This new statute accords the named plaintiffs all of the individual relief which they have sought in this litigation. Despite the class certification, the case is moot and plaintiffs lack standing because plaintiffs were not, at the time of their commitment or at the time of class certification, among the group of persons whose parents retain any control over the commitment decision under the new Pennsylvania law, *i.e.*, children under fourteen years of age. *See Hall* v. *Beals*, 396 U.S. 45 (1969).

Even if the disposition of this appeal were not controlled by the mootness and standing doctrines, the constitutionality of the new Pennsylvania statute

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[19] [E]xcepting the right to notice and counsel any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations when the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

A. 811 n. 26.

should not be reviewed by this Court prior to a decision on this question by the district court. Indeed, the district court expressly left open to the state the option of revising its own procedures, in a manner consistent with due process, as an alternative to the procedures it ordered. The district court's judgment as to whether the new statute satisfies due process requirements should precede a judgment by this Court.

If the Court determines to reach the merits, its decision should sustain the principle that due process requires access to counsel and the right an an evidentiary hearing in connection with the commitment of a child to a mental institution, and that these safeguards may not be waived by a parent of custodian. An erroneous commitment to a mental institution imposes very substantial harm on a child both by the very nature of institutionalization and because of the harmful conditions that exist in many mental institutions in this country. The risk of error in psychiatric recommendations to commit a child are high. Decisions to commit children are frequently made hurriedly and with very little information. Institutional psychiatrists have a strong predisposition to recommend commitment in doubtful cases, and this tendency exacerbates the general unreliability of psychiatric diagnoses. The risk of error can be substantially reduced by the participation of counsel and a full evidentiary hearing. The burden involved would not be substantial and might very well be offset by cost savings resulting from the elimination of unnecessary inpatient treatment.

There are strong reasons not to permit a parent or custodian to waive the child's due process rights. In many instances, commitment of a child is sought by a welfare agency standing "in loco parentis", although

the agency has little real connection with the child. Nor does the consent of a natural parent protect against serious error. Even when a parent is acting in the best of faith, his decision may be the product of great stress, acquiescence in the recommendation of the institutional psychiatrist, or lack of knowledge of the availability of less restrictive treatment alternatives. And in some cases, the interests of the parent will be in conflict with those of the child. The parent may simply not want to live with a difficult child; or commitment of the child may serve to deflect attention from broader mental health problems of the family as a whole.

ARGUMENT

I.

THE COURT SHOULD NOT REACH THE MERITS OF THIS APPEAL

The enactment of Act No. 143, S.B. 1025 by the State of Pennsylvania on July 9, 1976 is a fundamental change in circumstance, dictating that this appeal *not* be decided on the merits.

A. Plaintiffs' Individual Claims Are Now Moot, and Plaintiffs Lack Standing to Represent Those Children Who Continue to Have a Live Controversy With Defendants

All of the plaintiffs in this suit were over fourteen years of age when they were committed to a mental institution under the challenged statute, 50 PA. STAT. ANN. §§ 4402-03. The statute has now been amended to provide that children fourteen years and older cannot be committed against their will without a full evidentiary hearing. Act No. 143, S.B. 1025, §§ 201-206 (July 9, 1976).

It is settled that the appeal must be decided in light of the new statute. *Fusari* v. *Steinberg,* 419 U.S. 379, 387 (1974); *Allee* v. *Medrano,* 416 U.S. 802, 819-20 (1974); *California Bankers Association* v. *Shultz,* 416 U.S. 21, 49 n.21, 53 (1974); *Diffenderfer* v. *Central Baptist Church,* 404 U.S. 412, 414 (1972); *Hall* v. *Beals,* 396 U.S. 45, 48 (1969). This statute has granted plaintiffs all of the individual relief they sought in the courts. Thus, with respect to their individual claims, the case is moot for want of a present controversy. *Board of School Commissioners* v. *Jacobs,* 420 U.S. 148 (1975); *cf. Johnson* v. *N.Y. State Board of Education,* 409 U.S. 259 (1972).

In the circumstances of this case, class certification does not alter the conclusion of mootness. It is axiomatic that plaintiffs "cannot represent a class to which they do not belong." *Rosario* v. *Rockefeller,* 410 U.S. 752, 759 n.9 (1973); *Bailey* v. *Patterson,* 369 U.S. 31, 32-33 (1962). The district court certified a class of

> all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966.

A. 844. However, by enacting Act No. 143 after the district court's judgment, the Pe. nsylvania legislature has drawn a sharp line between the various members of plaintiffs' original class.

Unlike the situation prior to the statutory change, the only children who can now be committed without an evidentiary hearing are allegedly mentally ill children under 14 and children who are allegedly mentally retarded. Therefore, only they continue to have a live controversy with defendants. Since plaintiffs were not

members of either of these groups at the time of their commitment, they lack standing to represent them now.

The situation mirrors that presented in *Hall* v. *Beals, supra.* There, suit challenging Colorado's six-month residency requirement for voting was instituted by persons who were denied the right to vote because they had resided in the state for only five months. The case was certified as a class action. By the time the case reached this Court, Colorado had enacted legislation reducing the requirement from six to two months. This Court held that the case was moot.

> . . . [T]he appellants' opposition to residency requirements in general cannot alter the fact that so far as they are concerned nothing in the Colorado legislative scheme as now written adversely affects either their present interests, or their interests at the time this litigation was commenced. Nor does the result differ because the appellants denominated their suit a class action on behalf of disenfranchised voters. The appellants "cannot represent a class of [which] they are not a part,"—that is the class of voters disqualified in Colorado by virtue of the new two-month requirement, a class of which the appellants have never been members.

396 U.S. at 48-49. (Citations omitted.)

The instant case is unlike *Sosna* v. *Iowa,* 419 U.S. 393 (1975) and *Franks* v. *Bowman Transportation Co.,* 424 U.S. ——, 96 S.Ct. 1251 (1976), where plaintiffs whose individual claims had become moot were allowed to continue to represent a class. The crucial distinction is that, at the time of this Court's decisions in both *Sosna* and *Franks,* the members of the class who continued to have a live controversy with the defendants were in the same position that the named plaintiffs

were in as of the dates those suits were filed and the classes certified. In the case *sub judice,* however, plaintiffs were never members of the class which continues to have a live controversy with defendants.

The record in the court below did not focus on the questions presented by the new statute with regard to the commitment of children in this more limited class. It did not in any respect address the problems involved in utilizing a different commitment scheme for mentally retarded children and mentally ill children below 14 than for mentally ill children over the age of 14. For these additional reasons, there is now missing with respect to these questions that "concrete adverseness which sharpens the presentation of issues, upon which the court so largely depends for illumination of difficult constitutional questions." *Baker* v. *Carr,* 369 U.S. 186, 204 (1962). The judgment of the district court should be vacated and the case dismissed as moot.

B. The New Statute Should Not Be Reviewed Without a Decision as to Its Constitutionality by the District Court

This Court has declined to decide constitutional issues unless they are presented "in clear-cut and concrete form" (*Rescue Army* v. *Municipal Court,* 331 U.S. 549, 584 (1947)), on a record adequate to permit an informed decision. *Storer* v. *Brown,* 415 U.S. 724, 739-40 (1974); *Cowgill* v. *California,* 396 U.S. 371 (1970) (Harlan, J., concurring); *International Brotherhood of Teamsters* v. *Denver Milk Producers, Inc.,* 334 U.S. 809 (1948).

In *Fusari* v. *Steinberg,* 419 U.S. 379 (1975), for example, a three-judge court determined that Connecticut's procedures for assessing a recipient's continued eligibility for unemployment benefits violated due

process guarantees. Subsequent to the lower court's decision, the Connecticut legislature enacted a new law revising the applicable procedures. Noting that the change in state law might "alter significantly the character of the system considered by the District Court," the Court held that it would be inappropriate to decide the issues presented. 419 U.S. at 380. The judgment was vacated and the case remanded to the district court for reconsideration in light of the new law.

The same action would be appropriate here. The adequacy of the new procedures to assure constitutional rights has never been considered by the district court. There is no record on this question. In its order, the district court explicitly left open to the state the option of devising its own procedures, consistent with due process rights:

> Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out.

A. 800 n. 16.

If this appeal is not disposed of on grounds of mootness or standing, the Court should vacate the district court's order and remand the case to the district court to hear evidence concerning the efficacy of the new system and to reconsider its judgment in light of the statutory changes.

C. The Constitutionality of Commitment Procedures for Children Is Raised in Another Case Presently Pending on the Appeal Docket of the Court

In considering whether to reach the merits of this appeal, it may be relevant to note that the constitu-

tional questions raised by commitment procedures which permit a parent or custodian to authorize the commitment of a child over his objection and without a hearing are squarely presented in *J. L.* v. *Parham,* 412 F.Supp. 112 (M.D.Ga. 1976), *appeal docketed,* No. 75-1690 (May 21, 1976).[20] The *J. L.* case involves none of the procedural problems that obscure the issues raised in the instant appeal.

The mental commitment statutes challenged in *J. L.* are typical of those generally in effect. Children under the age of 18 can be committed to institutions for the mentally ill against their will, at the request or with the consent of their parents or custodians. No child under 18 is afforded notice, an opportunity to consult with counsel or an evidentiary hearing, either prior to or following commitment. There are no requirements—as there are in Pennsylvania—that a child be interviewed by more than one psychiatrist, or that alternatives to hospitalization be considered by hospital staff.[21] There have been no changes in state law.

J. L. v. *Parham* was decided by a three-judge district court favorably to the claims of the plaintiffs and the class they represent on February 21, 1976. Appellants timely filed a notice of appeal and submitted a jurisdictional statement on May 21, 1976. Appellees' Motion for Plenary Review or in the Alternative to Affirm was filed on June 11, 1976. The case is thus ready for action by the Court and can be heard and decided in the October 1976 Term. For these reasons, the undoubted importance of the issues originally

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[20] Appellees in *J. L.* are among the amici here.

[21] GA. CODE ANN. § 88-503.

raised in the instant case does not militate in favor of reaching the merits of this appeal.

* * *

Because of their concern that the important questions involved be decided in a context that permits their proper consideration, amici believe that a decision on the merits should not be made in the case *sub judice.* Nevertheless, in the discussion that follows, amici have set forth their arguments with respect to the necessity of evidentiary hearing rights in connection with the commitment of children, so that if the Court does reach the merits, these arguments can be considered.

II.

THE DUE PROCESS CLAUSE PROHIBITS THE COMMITMENT OF A CHILD TO A MENTAL INSTITUTION WITHOUT AN EVIDENTIARY HEARING, REGARDLESS OF THE CONSENT OF THE PARENT OR CUSTODIAN

A. Due Process Requires Access to Counsel and an Evidentiary Hearing in Connection with Involuntary Civil Commitments

"There can be no doubt that involuntary commitment to a mental hospital . . . is a deprivation of liberty which the State cannot accomplish without due process of law." *O'Connor* v. *Donaldson,* 422 U.S. 563, 580 (1975) (Burger, C. J., concurring). A "[c]ommitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding." *Id.*

Just last Term, this Court identified the factors that must be considered in determining the requirements of due process in a particular context:

> [I]dentification of the specific dictates of due process generally requires consideration of three

> distinct factors: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Mathews v. *Eldridge,* 424 U.S 319, ——, 96 S.Ct. 893, 903 (1976). *See also Wolff* v. *McDonnell,* 418 U.S. 539, 560 (1974); *Cafeteria and Restaurant Workers Union* v. *McElroy,* 367 U.S. 886, 895 (1961).

Consideration of these factors makes clear that due process requires that children committed to a mental institution be afforded access to counsel and the right to an evidentiary hearing to determine whether institutionalization is appropriate. First, enormous harm can result to a child from erroneous commitment. Second, there is a substantial risk of error in the present procedure for the commitment of juveniles, and this risk can be vastly reduced by a suitable hearing procedure where the basis for the commitment and the alternatives available can be dispassionately considered. And, third, the availability of hearings in the commitment situation is not unduly burdensome.

1. A Child Suffers Great Injury From An Erroneous Commitment

a. *Impact of Institutionalization*

A number of considerations underscore the substantial injuries and disabilities that result from an erroneous commitment.

First, commitment to a mental institution destroys the "continuity of relationships, surroundings and environmental influences [which] are essential for a child's normal development." J. Goldstein, A. Freud, and A. Solnit, Beyond the Best Interests of the Child 21 (1973).[22] Moreover, the committed child is placed in an environment characterized by constant staff turnovers, thus making it difficult, if not impossible, for him to develop new stable relationships. In *J. L.* v. *Parham, supra,* a psychiatrist described the impact of this dislocation on amicus J. L.:

> One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey.

J. L. v. *Parham, supra,* Deposition of Dr. Eli C. Messinger at 65. (Hereafter, "Mess. Dep.")

Second, placement in a mental institution necessarily interrupts a child's education, and frequently no alternative educational services are provided. At St. Elizabeths Hospital in Washington, D.C., for example, many

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[22] The authors further point out that disruption to the continuity of relationships is harmful for both young children and those of adolescent age. J. Goldstein, et al., supra, at 33-34.

children receive little or no education. *See Mills* v. *Board of Education* (D.D.C. No. 1939-71), Report to the Court of the D.C. Board of Education at 22-23 (April, 1975). No educational services at all are offered to children at Mississippi State Hospital. *D.L.K.* v. *Stubbs, supra,* Defendants' Answer to Interrogatory #10.[23]

Third, the committed child is denied the opportunity to explore and discover the world around him. Instead, he is placed in a "total institution"—"a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." E. GOFFMAN, ASYLUMS xiii (1961). *Cf. In re Gault,* 387 U.S. 1 (1967).[24] Compliant and passive behavior is demanded of patients in the name of institutional efficiency. This situation is:

> diametrically opposed to the developmental needs of children. . . . Such role indoctrination is contrary to a juvenile's need to establish a sense of initiative within reasonable self-imposed limits and controls. . . . Although decisions about what to wear, when to eat or whom to visit may seem trivial, they are important arenas of self-expression. The lack of flexibility that characterizes mental hospital procedures does not foster the child's development of a sense of individuality or personal responsibility.

Poe v. *Mathews, supra,* Affidavit of Dr. Eli C. Messinger at 3-4. (Hereafter, "Mess. Aff."). Indeed, confinement in an institution frequently produces what is known as "institutional neurosis," a condition characterized by apathy, lack of initiative, loss of individuality and a deterioration in personal habits. R. BARTON, INSTITUTIONAL NEUROSIS (1959) as cited in D. VAIL, DEHUMANIZATION AND THE INSTITUTIONAL CAREER 140-144 (1966).[25]

Finally, the adverse effects of commitment do not end when the child is released from the institution. Both the record in this case and the professional literature demonstrate the scarring effect of being labelled "mentally ill." *See* A. 475, 574-75, 596, and 622.[26]

> [B]eing an ex-mental patient is more of a liability than being an ex-criminal in the pursuit of hous-

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[23] *See also Martin M.* v. *Shepherd, supra,* Testimony of Mr. Karl K. at 6 (Michael K. received "very little" schooling in the year in which he was confined at Connecticut Valley Hospital). (Hereafter, "Mr. Karl K., T. ——").

[24] The fact of the matter is that, however euphemistic the title, a "receiving home" or an "industrial school" for juveniles is an institution of confinement in which the child is incarcerated for a greater or lesser time. His world becomes "a building with whitewashed walls, regimented routine and institutional hours • • •." Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, state employees, and "delinquents" confined with him for anything from waywardness to rape and homicide.

387 U.S. at 27.

[25] This situation is sometimes exacerbated by the use of psychotropic drugs, administered for the purpose of pacifying the child, rendering him more susceptible to management. *See infra,* p. 30.

[26] Last Term, in *Paul v. Davis,* 424 U.S. ——, 96 S.Ct. 1155 (1976), this Court again recognized that "stigma" resulting from government action is "an important factor in evaluating the extent of harm worked by that act, . . ." 96 S.Ct. at 1164. *See also Wisconsin* v. *Constantineau,* 400 U.S. 433 (1971).

> ing, jobs, and friends. Mental patients have for years been regarded with more distaste and less sympathy than virtually any other disabled group in our society. . . .

Rabkin, *Public attitudes toward mental illness: a review of the literature,* SCHIZOPHRENIA BULLETIN at 10 (Issue #10, Fall 1974).[27]

What is worse, a formerly committed individual tends to perceive society's negative response to him as a valid measure of his personal worth. The label becomes a "double-edged blade," causing "him to demean himself and to magnify social ostracism." *In re Ballay,* 482 F.2d 648, 669 (D.C. Cir. 1973). *See also* Cumming and Cumming, *On the Stigma of Mental Illness,* 1 COMMUNITY MENTAL HEALTH JOURNAL 135, 136 (1965).

The problems of stigma are increased for children because children are more impressionable than adults and are even more likely to accept as true society's judgment that they are "crazy." A child also faces a

[27] In a study reported in Tringo, *The hierarchy of preference toward disability groups,* 4 JOURNAL OF SPECIAL EDUCATION 295 (1970), it was found that of 21 disability groups including ex-convicts and alcoholics, the mentally ill ranked lowest in public esteem. *See also* J. NUNNALLY, POPULAR CONCEPTIONS OF MENTAL HEALTH: THEIR DEVELOPMENT AND CHANGE 42-51 (1961). It is important to note that the general public associates mental illness with the fact of hospitalization, but does not attach this label to less drastic forms of psychiatric or psychological therapy. *See* Goffman, *Career of the Mental Patient,* 22 PSYCHIATRY: JOURNAL FOR THE STUDY OF INTERPERSONAL PROCESSES 123 (May 1959); Johannsen, *Attitudes toward mental patients: a review of empirical research,* 53 MENTAL HYGIENE 218 (1969); Phillips, *Public identification and acceptance of the mentally ill,* 56 AMERICAN JOURNAL OF PUBLIC HEALTH 755 (1966).

peer group less tolerant of different experiences and is more likely to find himself socially outcast. Returning to school presents special problems for children:

> [F]ew students are mature enough to be entirely at ease with the child newly returned from a mental hospital. The failure of hospitals to provide educational programs for many juvenile mental patients means that there is a significant learning gap to overcome in addition to the social problems. Behind in their schoolwork, embarassed by peer group questioning, and under the watchful eye of school administrators, juveniles have a particularly difficult time reintegrating themselves into the school routine.

Poe v. *Mathews, supra,* Mess. Aff. at 6. *Cf.* N. HOBBS, FUTURES OF CHILDREN: CATEGORIES, LABELS, AND THEIR CONSEQUENCES 131 (1974).

In the case of a child who is actually in need of commitment to a mental institution, these detrimental effects are the unfortunate price that must be paid to enable the child to overcome mental illness that cannot be treated by less drastic means. But where a child is committed unnecessarily, he obviously pays a very heavy price for the error.

b. *The Harmful Conditions at Many Institutions*

The preceeding discussion addresses the consequences to a child of commitment, apart from the question of quality of the available facilities. But the conditions in many of these institutions are not fit for the confinement of children.

The Joint Commission on the Mental Health of Children [28] has reported that "most" mental institutions for children are "disgraceful and intolerable."

> Each year, increasing numbers of [children] are expelled from the community and confined in large state hospitals so understaffed that they have few, if any, professionals trained in child psychiatry and related disciplines.
>
> * * *
>
> In most of these hospitals the usual practice is to place youngsters in wards with adult patients, frequently with those who are in an advanced stage of mental deterioration. These children and youth receive little, if any, therapeutic care, and no provision is made for the continuation of their education. An imprecisely determined number are left to "rot on the back wards," condemned to a hopeless life of continuing institutionalization.

CRISES IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's: REPORT OF THE JOINT COMMISSION ON THE MENTAL HEALTH OF CHILDREN 5, 269 (1969).[29]

Unfortunately, the institutions to which amici have been committed conform to this description. The Joint Commission on Accreditation of Hospitals

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[28] The Joint Commission on the Mental Health of Children was established by the U.S. Department of Health, Education and Welfare pursuant to amendments to the Social Security Act, July 30, 1965, Pub. L. 89-97, § 231(a)-(d), 79 Stat. 360. It was composed of "representatives of leading national medical, welfare, educational, and other professional associations, organizations, and agencies active in the field of mental health of children." *Id.* § 231(c).

[29] *See also* Cohen, Granger, Provence, and Solnit, *Mental Health Services*, in ISSUES IN THE CLASSIFICATION OF CHILDREN, Vol. II, 106-07 (N. Hobbs ed. 1975).

("JCAH")[30] has found that St. Elizabeths Hospital lacks sufficient numbers of qualified professional staff. JCAH RECOMMENDATIONS AND COMMENTS ON ST. ELIZABETHS HOSPITAL 3 (Sept., 1975). (Hereafter, "JCAH ST. ELIZ. REC."). At Mississippi State Hospital, where amicus D.L.K. was confined, many nursing positions remain unfilled. As a result, between midnight and eight in the morning only one registered nurse is on duty for approximately 3,500 patients. MISSISSIPPI LEGISLATIVE AUDIT COMMITTEE, REPORT TO THE MISSISSIPPI LEGISLATURE: A PERFORMANCE EVALUATION OF THE MISSISSIPPI STATE HOSPITAL AT WHITFIELD 16 (Sept., 1975) (Hereafter, "MISS. EVAL. RPT."). Inadequate staffing has also been identified as a serious problem in state mental institutions in Georgia. REPORT OF THE GEORGIA STUDY COMMISSION ON MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH 81-86, C-2 (1973). (Hereafter, "GA. COMM. RPT.").

Despite the lack of staff to supervise and protect them, children in these institutions are frequently confined with adults. In Georgia:

> [in] many cases, youth are housed on geographic units with disturbed adults. Staff were concerned that in these units adolescents are continuously confronted with pathological adult behavior patterns at a time in their psychological development when healthy role models are needed to help them develop an individual sense of identity.

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[30] The Joint Commission on Accreditation of Hospitals is a private body which inspects a wide range of medical treatment facilities and certifies them according to professionally accepted standards. *JCAH, Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents* iii (1974).

GA. COMM. RPT. at C-1. *See also J.L.* v. *Parham, supra,* Deposition of Dr. Lawson H. Bowling at 25 (hereafter, "Bowling Dep."); Mess. Dep. at 33-35. And in Mississippi, juveniles are placed on wards with "adults, persons charged with crimes, alcoholic patients, narcotic patients, sex offender patients and aggressive homosexual patients." *D.L.K.* v. *Stubbs, supra,* Defendants' Answers to Interrogatories #12-13.[31]

The physical facilities at these institutions are also severely deficient and even dangerous. The Mississippi State Hospital, where amicus D.L.K. was confined

> has been unable to maintain its buildings. . . . The plaster on the walls of many of the buildings is peeling and crumbling. Employees and patients accept the leaking ceilings and faulty plumbing as a way of life. The presence of rats, roaches, and flies are a serious sanitation problem.

MISS. EVAL. RPT. at 13-14. The JCAH found that this facility had undesirable odors, broken windows, unrepaired screens and wallboards and was a fire hazard. JCAH RECOMMENDATIONS AND COMMENTS ON MISSISSIPPI STATE HOSPITAL AT WHITFIELD 2, 5-6 (April, 1975) (Hereafter, "JCAH MISS. REC."). At St. Elizabeths in Washington, D.C., the JCAH found that some buildings did not even show evidence of routine clean-

[31] Amicus Michael K. was confined on both locked and open wards with adults for nearly the entire duration of his year-long confinement at Connecticut Valley Hospital. *Martin M.* v. *Shepherd, supra,* Mr. Karl K., T. at 5-7. Similarly, children and adults are mixed on many of the wards at St. Elizabeths Hospital. *See Poe* v. *Mathews, supra,* Defendants' Answer to Plaintiffs' First Interrogatory #27. Overall, fifty percent of all juveniles admitted to state, county and private mental institutions in 1971 were placed on adult wards. *See National Institute of Mental Health,* HOSPITAL INPATIENT TREATMENT UNITS FOR EMOTIONALLY DISTURBED CHILDREN, UNITED STATES, 1971-72 1 (1972).

ing and maintenance. JCAH ST. ELIZ. REC. at 7. The Georgia institutions not only have inadequate bed space but lack sufficient space to conduct appropriate therapy programs. GA. COMM. RPT. at C-1.

Given these facts, it comes as no surprise that several of the institutions in which amici have been confined have been denied accreditation.[32] Dr. W. L. Jaquith, former director of Mississippi State Hospital, testified:

> I couldn't meet . . . these standards that have been submitted. There is no way . . . to meet them. The hospital was built in 1925, opened in 1935. . . . One of the things that I would have to be perfectly honest with the Court is . . . in the long-term cottages and buildings, there is little privacy. *It is dehumanizing.*

McCraw v. *Jaquith,* Civil No. 92, 361 (Chancery Court of the First Judicial District, Hinds County, Miss.), Testimony at 63 (April 18, 1974). (Emphasis added). Accreditation also has been denied to St. Elizabeths Hospital in Washington, D.C. (*see* letter of November 24, 1975 from JCAH to Dr. Roger Peele, Acting Superintendent, St. Elizabeths Hospital) and to several of the mental institutions in Georgia in which juveniles are confined. *See J.L.* v. *Parham, supra,* Deposition of Dr. Douglas Skelton at 11-12.[33]

[32] Such accreditation by the JCAH is required for an institution to receive reimbursement from the federal medicaid program for in-patient psychiatric services provided to children. 42 U.S.C. § 1396d(h)(1)(A).

[33] JCAH also offers a separate accreditation to mental hospitals which specifically qualify to treat juveniles and adolescents. Only 21 state and county mental hospitals in the entire country are so accredited. Letter dated May 26, 1976 from JCAH to Linda Lipton, counsel for amici.

Apart from the inadequate staffing and deficient physical facilities, it has recently been reported that at state mental institutions psychotropic medication is frequently administered to patients to sedate them for the convenience of the institutional staff, without the supervision of physicians and in hazardous circumstances. *See* Testimony of A. Brandt and J. W. Ellis, Hearings on Institutional Drug Abuse Before the Subcommittee on Juvenile Delinquency of the Senate Committee on the Judiciary, 94th Cong., 1st Sess. (1975). The long term use of such medication on children can have particularly harmful side effects such as retardation of a child's growth, increase in heart rate, involuntary body movements, elevation of blood pressure and acute toxic psychotic reactions. *J. L.* v. *Parham, supra,* Mess. Dep. at 32.

The poor quality of mental facilities available for children in this country only serves to underscore the enormous harm to a child that results from an erroneous decision to commit.

2. THERE IS A SUBSTANTIAL RISK OF ERROR IN PSYCHIATRIC RECOMMENDATIONS OF COMMITMENT, AND THIS RISK CAN BE REDUCED BY APPROPRIATE PROCEDURAL SAFEGUARDS

a. *The Risk of Error*

Despite the enormous harm to the child that results from an erroneous decision to commit, due process might not require a hearing if the likelihood of error was relatively slight. In fact, however, there is a very substantial risk of error in psychiatric recommendations of confinement.

i. *Institutional Psychiatrists are Predisposed to Recommend Confinement*

The tendency of psychiatrists connected to mental institutions to prescribe institutionalization for persons not in need of confinement has been widely noted and has been confirmed by empirical study.[34] The Georgia Study Commission on Mental Health Services for Children and Youth, for example, found that more than half of the institutionalized children in Georgia did not need to be so confined. *J.L.* v. *Parham, supra,* 412 F. Supp. at 122. And a recent report by the National Institute of Mental Health noted that only 26 percent of the patients below the age of 20 confined at St. Elizabeths Hospital were in need of institutionalization. NATIONAL INSTITUTE OF MENTAL HEALTH, STATISTICAL NOTE 115, CHILDREN AND STATE MENTAL HOSPITALS at 4 (1975).

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[34] *See, e.g.,* T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 105-21 (1966); Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process,* 75 Colum. L. Rev. 897, 900 (1975); Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways,* 4 TRIAL 29, 32-33 (Feb./March 1968); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions,* 62 CALIF. L. REV. 840, 863-68 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CALIF. L. REV. 693, 711-19 (1974); Livermore, Malmquist, and Meehl, *On the Justifications for Civil Commitment,* 117, U. PA. L. REV. 75, 83-84 (1968); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events,* 18 J. OF CON. PSYCHOLOGY 397 (1954); *Note, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework,* 84 YALE L. J. 1540, 1553-54 (1975); *People* v. *Burnick,* 14 Cal. 3d 306, 535 P. 2d 352, 121 Cal. Rptr. 488 (1975); *In re Long,* 25 N.C. App. 702, 214 S.E. 2d 626, 629, *cert. denied,* 288 N.C. 241, 217 S.E. 2d 665 (1975); *J.L.* v. *Parham, supra,* Deposition of Dr. Walter R. Gove at 95.

Rappeport, Lassen and Gruenwald studied the progress of 38 persons who obtained release from a state mental institution over the objection of the institution's psychiatrists.[35] After a year or more, nearly half of the 38 had made a satisfactory adjustment to the community, *i.e.*, they had not been in serious trouble with the law, had not been rehospitalized, and were caring for themselves. Of equal significance, no serious anti-social behavior occurred among any of the 38, although a number of patients who did not adjust were involved in minor accidents or criminal infractions.[36]

A number of factors explain the tendency of psychiatrists to recommend institutionalization where it is not needed. First, the ethics of the medical profession dictate erring on the side of caution.[37] Because the consequences of not treating an individual for a suspected

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[35] Rappeport, Lassen and Gruenwald, *Evaluation and Follow-up of State Hospital Patients Who Had Sanity Hearings,* 118 Am. J. Psychiat. 1078 (1962). Twenty-six of the thirty-eight were released after a judicial hearing. The remaining twelve escaped.

[36] These findings are further supported by a study conducted as follow-up to this Court's decision in *Baxstrom* v. *Herold,* 383 U.S. 107 (1968). Each of 969 patients who had been detained in maximum security hospitals by the New York Department of Corrections because psychiatrists had determined them to be mentally ill and too dangerous for release or even for transfer to civil hospitals were transferred to civil hospitals. Within a year after their transfer, 147 had been discharged to the community and only 7 had to be recommitted to a prison hospital. Hunt and Wiley, *Operation Baxstrom After One Year,* 124 Am. J. Psychiat. 974 (1968). *See also* Steadman and Keveles, *Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70,* 129 Am. J. Psychiat. 304 (1972) and studies cited in Ennis and Litwack, *supra,* 62 Calif. L. Rev. at 711-16.

[37] *See* T. Scheff, supra, at 105-21; Ellis, *supra,* at 865-66; Rosenhan, *On Being Sane in Insane Places,* 13 Santa Clara Law. 379, 385 (1973).

physical illness are likely to be more serious than the consequences of unnecessary treatment or further diagnosis, such caution, in the case of physical illness, may work to the benefit of the patient. But in the case of mental illness, where "caution" can result in unnecessary commitment to a mental institution, this is clearly not the case.

Second, psychiatrists tend to think in terms of psychopathology. Shah, *Crime and mental illness: some problems in defining and labeling deviant behavior,* 53 Mental Hygiene 21, 26 (1969); *J.L.* v. *Parham, supra,* Mess. Dep. at 16-17. They are apt to diagnose mental illness from ambiguous behavior rather than recognizing equally plausible, yet non-pathological explanations for the behavior. Kumasaka and Gupta, *Lawyers and Psychiatrists in the Court: Issues on Civil Commitment,* 32 Md. L. Rev. 6, 34 (1972). An example of this was recorded in a study conducted by Dr. Rosenhan, *On Being Sane In Insane Places,* 13 Santa Clara Law. 379 (1973). In the study, eight normal persons presented themselves for voluntary admission at twelve different mental institutions. The only symptom the subjects pretended to exhibit was hearing voices. Beyond this, they acted normally and were truthful in describing themselves and their history. In every instance, the subject was admitted to the hospital with a diagnosis of schizophrenic or manic-depressive psychosis.

Rosenhan described one of his subjects as having

> had a close relationship with his mother but was rather remote from his father during early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relation-

> ship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked.

Id., at 387. But on the basis of the same information, the case summary prepared by the institution portrayed a mentally ill individual:

> This white 39 year-old male . . . manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of children, spankings. And while he says that he has several good friends, one senses considerable ambivalence embedded in those relationships also . . . .

Third, reinforcing the tendency of psychiatrists to commit persons who do not need to be institutionalized is the fact that erroneous denials of institutionalization are far more likely to come to their attention than erroneous admissions. When a psychiatrist mistakenly concludes that someone is not in need of institutionalization, that person will likely be brought back to the institution, and the psychiatrist will learn of his mistake. When someone is mistakenly committed, however, subsequent "normal" behavior will be attributed to the positive effects of institutionalization rather than to a mistaken commitment. For these reasons, psychiatrists become aware of their mistakes only when they deny commitment, and this further inclines them to a decision to commit in future doubtful cases. *See* Dershowitz, *supra,* at 32-33; *Note, The Role of Counsel in the Civil Commitment Process, supra,* at 1554.

Fourth, by erring on the side of institutionalization rather than outpatient care, the psychiatrist avoids the possibility that he or the institution will be held responsible, or even liable, if the child should cause harm to himself or others after institutionalization has been denied. *Cf. Hicks* v. *United States,* 511 F. 2d 407 (D.C. Cir. 1975); *Underwood* v. *United States,* 356 F. 2d 92 (5th Cir. 1966); *Fair* v. *United States,* 234 F. 2d 288 (5th Cir. 1956). There is no comparable risk in the case of mistaken commitments. *See* Dershowitz, *supra,* at 32-33; Bazelon, *supra,* at 400; *Note, The Role of Counsel in the Civil Commitment Process, supra,* at 1554; *Poe* v. *Mathews, supra,* Mess. Aff. at 11.

Finally, institutional psychiatrists have knowledge of and confidence in the benefits of institutionalization. On the other hand, they frequently lack knowledge in the use and availability of community-based facilities or other possible outpatient alternatives. This familiarity with one alternative and lack of familiarity with the other increases the likelihood of a recommendation of commitment. *See* A. 608-09; *J.L.* v. *Parham, supra,* Mess. Dep. at 16-17.

ii. *Psychiatric Judgments are Inherently Unreliable*

The Chief Justice has pointed out that "there can be little responsible debate regarding 'the uncertainty of diagnosis in this field and the tentativeness of professional judgment.'" *O'Connor* v. *Donaldson,* 422 U.S. 563, 584 (1975) (concurring opinion).

> Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists

still experience considerable difficulty in confidently and accurately diagnosing mental illness.

People v. *Burnick, supra,* 14 Cal. 3d at 326-27, 535 P. 2d at 365, 121 Cal. Rptr. at 501 (1975). *See also In re Ballay, supra,* 482 F. 2d at 665 (D.C. Cir. 1965); Ennis and Litwack, *supra,* at 719.

Experience with the insanity defense in the criminal law is a vivid reminder of the frequency with which psychiatrists disagree as to a diagnosis. In such cases, conflicting psychiatric evidence is the rule, not the exception:

> [M]edical witnesses time after time express directly opposite opinions in the witness box concerning the sanity of prisoners on trial. . . .

Blocker v. *United States,* 288 F. 2d 853, 869 n. 28 (D.C. 1961) (Burger, J., concurring).[38]

The point, simply, is that diagnosis of mental illness is an area of inherent uncertainty and consequent high risk of error.

iii. *Decisions to Confine Children to Mental Institutions Are Generally Made Without Adequate Information or Adequate Exposure to the Child*

In the context of evaluating children whose commitment to a mental institution is proposed, the likelihood of error is exacerbated by the limited information on which the commitment decision is generally based.

[38] An example of the inability of psychiatrists to agree on the diagnosis of a child is found in the record in *J.L.* v. *Parham, supra.* One of the amici there received the conflicting diagnoses of adjustment reaction of childhood and hyperkinetic disorder. *See* Mess. Dep. at 18.

A psychiatrist should have as much knowledge as possible of a child's situation in order to decide whether to institutionalize the child. S. CHESS, AN INTRODUCTION TO CHILD PSYCHIATRY 47 (2nd ed. 1969). Well established psychiatric procedure calls for several interviews with a child over a period of time. "It is rarely possible to do a complete mental status evaluation in less than two or three interviews." J. SIMMONS, PSYCHIATRIC EXAMINATION OF CHILDREN 6 (2nd ed. 1974); GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *The Diagnostic Process in Child Psychiatry* 313 in 3 REPORTS AND SYMPOSIUMS, REPORT No. 38 (1957); T. SCHEFF, *supra,* at 174."[39]

The reason for this is that a child is likely to experience deep anxiety at the first clinical interview and is therefore unlikely to place in the psychiatrist the trust and confidence requisite for a successful psychiatric evaluation. A. 478-79; J. SIMMONS, *supra,* at 1; GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 38, *supra,* at 338-42. In addition, children often experience great fluctuations in behavior over short periods of time, particularly in different settings. "Adolescence is normally a time of emotional turmoil, behavioral excesses and rapid change. One can expect alterations and fluctuations in behavior. . . ." *Poe* v. *Mathews, supra,* Mess. Aff. at 11. *See also* Ennis and Litwack, *supra,* at 723-24; T. SCHEFF, *supra,* at 174; A. 595.

In fact, however, psychiatric judgments on children whose commitment is sought are typically based on

[39] The Menninger Foundation recommends that evaluations be done by a team of specialists rather than by a lone psychiatrist. THE MENNINGER FOUNDATION CHILDREN'S DIVISION, DISTURBED CHILDREN: EXAMINATION AND ASSESSMENT THROUGH TEAM PROCESS (1969).

short interviews with the child. For example, in the instant case, the psychiatrist in charge of the unit at Haverford State Hospital in which the plaintiffs were held testified that admission evaluations last only 45 minutes to an hour, "or shorter." A. 47. And at St. Elizabeths Hospital in Washington, the overwhelming majority of children are committed on the same day in which application is made. *Poe* v. *Mathews, supra,* documents filed in response to Plaintiffs' First Interrogatories #26.

Compounding the problem of inadequate exposure to the child is the often unreliable information upon which admitting psychiatrists base their diagnoses of children. The applicant for admission, whether parent or state agency, is likely to be the psychiatrist's primary, and possibly sole, source of information.[40] The limitations of a state agency in this regard are obvious. But even when the parents are the applicants, the information conveyed is likely to be replete with distortions and inaccuracies. The parents themselves may be suffering from behavioral problems, or may be experiencing such anxiety and nervousness as to undermine the accuracy of their observations. A. 478. In the midst of the crisis situation which triggered the application for commitment, the parents "are more likely to focus on the behavioral characteristics of the child that

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[40] That psychiatrists often fail to obtain information from sources other than the petitioning state agency or parent was admitted by Dr. John Gates, Superintendent, Central State Hospital:

> Now the fact of the matter is, of course, that you don't always get information about the child from other sources, and the fact of the matter is that sometimes the people don't make the contacts they should make.

J.L. v. *Parham, supra,* Deposition at 6. *Cf.* A. 637-38.

they find unpalatable or which they consider sick and deviant." *J.L.* v. *Parham, supra,* Mess. Dep. at 10. Thus, they may omit crucial pieces of information or otherwise present biased information. S. CHESS, *supra,* at 73; A. 592.[41]

Experts in child psychiatry stress that information should be obtained from a wide variety of sources. Both joint and separate interviews should be conducted with the parents. J. SIMMONS, *supra,* at 116-17, 122; S. CHESS, *supra,* at 50-54. Yet state statutes generally do not even require that both parents participate in the commitment decision or that the psychiatrist consult with both parents. And, in fact, the psychiatrist often sees only one parent prior to institutionalizing a child. Four of the plaintiffs in the instant case, for example, were committed on application of only one parent. A. 788-89.

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[41] Even when the examining psychiatrists form different conclusions about the behavior of the child than does the parent, they are often inclined to identify with the parent and seek to satisfy him rather than the child.

> While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems most desperate, . . . who is closest to the psychiatrist in age and social outlook. . . .

Ellis, *supra,* at 868. (Citations omitted). *See also In re Long, supra.* An example of this was noted by Dr. Messinger in his testimony about one of the amici in *J.L.* v. *Parham, supra.* Joey's adoptive mother and her second husband described him as hyperactive and rebellious against and unwilling to listen to authority. His conduct in the psychiatric interview belied such an observation; Joey was cooperative and without hyperactivity. Faced with such a discrepancy, however, the psychiatrist chose to institutionalize him. Mess. Dep. at 12-13.

b. *The Right to Counsel and an Evidentiary Hearing Would Substantially Reduce the Risk of Error*

The procedures required by the due process clause depend on "the need for and usefulness of the particular safeguard in the given circumstances. . . ." Friendly, *Some Kind of Hearing,* 123 U. Pa. L. Rev. 1267, 1278 (1975). In cases of the commitment of children to mental institutions, there is an indispensible need for counsel and for a full evidentiary hearing.

In recognition of this, most state statutes grant these safeguards to adults in connection with involuntary commitment proceedings. *See, e.g.,* 50 Pa. Stat. Ann. § 4406; D.C. Code § 21-541; Cal. Welf. and Inst'ns Code § 5300-05; Mo. Stat. Ann. § 202.807; Rev. Code Wash. Ann. § 71.05. 310. And state and federal courts have uniformly held that these safeguards are constitutionally required.[42] The necessity of access to counsel and the right to a full evidentiary hearing to assure fundamental fairness is no less in the case of proceedings to commit children.

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[42] *See, e.g., Barry* v. *Hall,* 98 F. 2d 222, 225-26 (D.C. Cir. 1938); *Suzuki* v. *Quisenberry,* —— F.Supp. ——, Civ. No. 73-3854 (D. Haw. Feb. 24, 1976); *Doremus* v. *Farrell,* 407 F.Supp. 509 (D. Neb. 1975); *Kendall* v. *True,* 391 F. Supp. 413, 419 (W.D. Ky. 1975) (three-judge court); *Bell* v. *Wayne County General Hospital,* 384 F. Supp. 1085, 1091 (E.D. Mich. 1974) (three-judge court); *Lynch* v. *Baxley,* 386 F. Supp. 378, 388 (M.D. Ala. 1974) (three-judge court); *Lessard* v. *Schmidt,* 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (three-judge court), *remanded,* 414 U.S. 473 (1974) *on remand,* 379 F. Supp. 1376 (1974), *remanded,* 421 U.S. 957 (1975); *Dixon* v. *Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966, 974 (M.D. Pa. 1971) (three-judge court); *State ex rel. Fuller* v. *Mullinax,* 364 Mo. 858, 269 S.W. 2d 72 (1954); *State ex rel. Hawks* v. *Lazaro,* 202 S.E. 2d 109 (W. Va. 1974); *cf. Specht* v. *Patterson,* 386 U.S. 605, 608 (1967); *Minnesota ex rel. Pearson v. Probate Court,* 309 U.S. 270 (1940).

The value of counsel in this setting begins with the initial interview with the child.

> If prospective juvenile patients were able to see someone they knew was their advocate, in a setting outside the hospital examining room, they might present a lot more information and a lot different sounding information than in the interview with the psychiatrist in a hospital admitting office.

Poe v. *Mathews, supra,* Mess. Aff. at 13. In this interview the lawyer and the child can explore the question whether to contest the proposed commitment or acquiesce in it. The court below rightly concluded that a child may not waive his hearing rights until counsel is appointed and has consulted with the child. A. 811 n. 26.

This is particularly necessary when the hearing follows confinement as it does under the district court order. In that situation, the child is cut off from his friends and all outside contacts. He is told both by his parents and the staff of the institution that commitment is in his best interest. A. 284-85. Lacking "someone concerned with securing him [his] rights [with] . . . more mature judgment as to the steps he should take" (*Gallegos* v. *Colorado,* 370 U.S. 49, 54 (1962)), the child is likely to acquiesce in the commitment and waive his right to a hearing.[43] Such a waiver will more likely be the product of "fantasy, fright or despair"

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[43] A child is also subject to pressures toward waiver when the hearing precedes the commitment. The child's parents or social worker will be telling him that it is best to forego a hearing, as will the institutional psychiatrist. Once again, the child will have no one to whom he can turn to openly discuss his feelings. Without the benefit of independent consultation and advice, the child's decision is likely to be a reflection of the will of those seeking his commitment rather than a free and voluntary choice.

(*In re Gault, supra,* 387 U.S. at 55) than an "intentional relinquishment or abandonment" of a fully known right. *Johnson* v. *Zerbst,* 304 U.S. 458, 464 (1938).

If the hearing is not waived, the involvement of counsel will vastly improve the range and quality of the data that are brought to bear on the decision whether to commit a child. In addition to the likelihood that counsel will secure better information from the child, counsel will be in a position to obtain other relevant data that may not be volunteered by the parents, such as information relating to abuse of the child by the parents or prior attempts to secure commitment. *Poe* v. *Mathews, supra,* Mess. Aff. at 13. In addition, counsel can secure and present the opinions of a psychiatrist not associated with the institution as to the need for confinement and the possibilities of less restrictive forms of treatment that may be appropriate. This is particularly important because of the general unreliability of the recommendations to commit made by institutional psychiatrists.

The child's attorney would also have the opportunity independently to investigate alternative treatment facilities.[44] In this effort, social workers from state mental health departments or those connected to ju-

[44] In New York City for example, where counsel-advocates work within the admitting hospitals, one of their principal functions has been to seek alternatives to hospitalization satisfactory to their clients (and to the hospital as well) so that long-term hospitalization together with the disabilities and dependencies it involves can be avoided.

Andalman and Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic and A Proposal,* 45 Miss. L. J. 43, 47 (1974).

venile courts could be of assistance to counsel.[45] In some cases, counsel will locate alternatives to institutionalization to which the parents would agree, and services could be arranged in lieu of going forward with the commitment hearing.

An evidentiary hearing, with representation of the child by counsel, would provide an opportunity to delve into the accuracy of the facts upon which the psychiatric judgment is based, to the extent they are in dispute. As in other proceedings where a child's actions are at issue,[46] an evidentiary hearing before an impartial officer with due notice[47] and the opportunity to present and cross-examine witnesses,[48] will "en-

[45] *See, e.g.,* GA. CODE ANN. § 24A-601 to -02 which provides for a probation officer to assist juvenile courts in finding alternative placements for children under their jurisdiction, and Mich. Stat. Ann. § 14.800 (469) (2), requiring reports to be filed with the court in the course of civil commitment hearings by agencies or individuals knowledgeable about alternative treatment programs in the person's home community.

[46] Many of the facts that may be at issue in a commitment case are similar to those at issue in a delinquency proceeding. The court below found that the commitment of juveniles to mental institutions had been triggered by such alleged actions as "running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy. . . ." A. 790.

[47] Without adequate notice the right to a hearing is of little significance. *Mullane* v. *Central Hanover Trust Co.,* 339 U.S. 306, 314 (1950). Notice should include a statement of the factual and diagnostic bases for the proposed commitment, so that an adequate response can be prepared. *Cf. In re Gault, supra,* 387 U.S. at 33.

[48] In *Specht* v. *Patterson, supra,* 386 U.S. at 610, the Court held that persons have the right to present evidence and confront witnesses in commitment hearings held under the Colorado Sex Offenders Act. These rights are no less important here. While the right to appear personally is also essential if the juvenile is to have a fair opportunity to explain his behavior, the court below was

hance the possibility that truth will emerge from the confrontation of opposing versions and conflicting data." *In re Gault, supra,* 387 U.S. at 21.[49] An evidentiary hearing would also promote discussion and review of available programs offering alternative treatment services to those found at the mental institution in question.[50]

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cognizant of the fact "that situations exist where the absence of such persons from commitment proceedings may serve their own best interest." A. 805-06. Thus, it held that the right to appear personally may be waived, either by the juvenile or by the child's counsel, and that such a waiver shall be accepted by the impartial tribunal "upon a finding that the child is too ill to attend the proceedings." A. 806.

[49] The value of counsel is demonstrated by a study by Wenger and Fletcher. They monitored nearly 100 commitment hearings in one court and found that in 91 percent of the cases in which only the psychiatrist, respondent and referee were present, the psychiatrist recommended commitment. But in only 26 percent of the cases in which counsel represented the respondent was commitment recommended. Significantly, of respondents *without* counsel, 10 of 15 whom the authors judged not to be in need of commitment and all 25 who were thought to be borderline cases, were committed. Wenger and Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions,* 10 J. OF HEALTH AND SOC. BEH. 66, 68-71 (1969). *See also* Gupta, *New York Mental Health Information Service: An Experiment In Due Process,* 25 RUTGERS L. REV. 405, 437-38 (1974).

[50] Examination of alternatives is already required under some civil involuntary commitment schemes. *See, e.g.,* Rule 3, Mental Health Rules of the Superior Court of the District of Columbia, requiring that the D.C. Mental Health Commission file a report on each individual recommended for commitment setting forth "what less restrictive alternatives to hospitalization the Commission has considered, and why these alternatives will or will not be appropriate"; Mich. Stat. Ann. § 14.800 (469) (1) ("Prior to ordering any course of treatment, the court shall determine whether there exists an available program of treatment for the individual which is an alternative to hospitalization. The court shall not order hospitalization without a thorough consideration of available alternatives."); *see also* KAN STAT. ANN. § 59-2917 (effective July 1, 1976); OHIO REV. CODE § 5122.15(E) (effective August 1, 1976); and Rev. Code Wash. Ann. §§ 71.05.290(2) and 71.05.320(1). *Cf. J.L.* v *Parham, supra,* 412 F. Supp. at 124-25, 139, noting that 46 children in Georgia mental institutions could be cared for in less drastic, non-institutional environments such as small group crisis homes, specialized foster parent programs, or in their own communities with special home care services, and requiring the state to place these children in such appropriate facilities.

In short, counsel and an evidentiary hearing are the precise safeguards that will be effective in reducing the risk of error in the commitment of children to mental institutions. This procedure will necessarily expand the base of information on which a final decision is made, and provide the opportunity to consider conflicting professional diagnoses and alternative recommendations for treatment, where appropriate. And if a hearing is not held, participation of counsel will insure that a waiver is consistent with the best interests of the child.[51]

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[51] If an evidentiary hearing is to be held in non-emergency cases, it should precede the commitment, just as it does in cases of adults. In non-emergency situations, no harm can result from the brief delay caused by a pre-commitment hearing. But children who are found at a hearing not to be in need of commitment will be spared the deprivation of liberty and the harm they would have suffered as a result of mistaken institutionalization pending a post-commitment hearing. A child's sense of time is such that even a few days in a mental institution can seem a lifetime:

> Children and adolescents have a different sense of time than adults. Events of short duration can be experienced by juveniles as lengthy. The consequences of hospitalization—loss of schooling, exposure to frightening and disturbed behavior—will all take a serious toll on a youngster, regardless of the length of time spent inside the hospital walls.

Poe v. *Mathews, supra,* Mess. Aff. at 7. If the child in the non-emergency case is permitted to remain at home pending the hearing, the need for institutionalization may be altogether obviated:

> Since youngsters are quite fluid and change very quickly, a

3. A Child's Entitlement to an Evidentiary Hearing Would Not Impose a Substantial Burden on the State

There are over half a million admissions for inpatient treatment of psychiatric disorders made annually,[52] and evidentiary hearings are routinely accorded to adults who resist commitment and to children whose parents do not consent to commitment. The states have not found the right to an evidentiary hearing a great fiscal or administrative burden. Extending that right to all children would result in little additional cost.

In Georgia, for example, only 154 children were confined in institutions pursuant to voluntary procedures on January 31, 1976.[53] Nationally, only 9 percent of

delay will often allow a crisis to pass and thus avoid unnecessary hospitalization.

Id., at 14; A. 594-95.

Further, studies show that psychiatrists are more likely to recommend commitment when examining patients within a hospital setting. *See* Babigian, Gardner, Miles and Romano, *Diagnostic Consistency and Change in a Follow-up Study of 1215 Patients*, 121 Am. J. Psychiat. 895, 897 (1965). Possibly, this is true because of the impact on the individual of confinement with persons who are seriously disturbed. *Cf. U.S. ex rel. Schuster* v. *Herold*, 410 F.2d 1071, 1078 (2nd Cir. 1969). In any event, a delay in the hearing until after confinement increases the likelihood of commitment.

In the instant case, the claim of entitlement to a precommitment hearing was raised by the plaintiffs, but rejected by the district court. No notice of appeal from this ruling was filed, so the question is not raised on this appeal. Any decision the Court should render on the merits, however, should reserve this issue for resolution in a case in which it is appropriately presented. The issue is raised in each of the cases in which amici are plaintiffs.

[52] National Institute of Mental Health, Statistical Note 90, Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, U.S. 1971, Table I (1973). (Hereafter, "Stat. Note 90").

[53] *J. L.* v. *Parham*, 412 F.Supp. 141, 143 (M.D. Ga. 1976).

those receiving inpatient treatment are under eighteen years of age.[54] One out of every three of these children are now committed on an involuntary basis pursuant to an evidentiary hearing because their parents have objected to hospitalization.[55] Moreover, of the adults confined in state and county mental institutions, 53.9 percent have waived a hearing and committed themselves voluntarily[56] and, presumably, a substantial proportion of the children whose parents have consented would, after consultation with counsel, waive their hearings. Thus, the recognition of the hearing rights of children will result in only a minimal increase in the number of civil commitment hearings conducted. Indeed, as an erroneous commitment imposes a substantial unnecessary burden on the state in the form of costly inpatient care, an additional screening mechanism is likely to reduce overall costs to the state.

B. Parents or Custodians Should Not Be Permitted to Waive a Child's Due Process Rights Incident to a Civil Commitment

In the preceding section, it is argued that due process requires the availability of counsel and an evidentiary hearing in connection with the commitment of a child to a mental institution. In apparent recognition of this, the law of every state guarantees a child whose parents do not consent to a commitment the same hearing

[54] Stat. Note 90.

[55] This calculation is based on nationwide data on state and county mental hospitals reported in National Institute of Mental Health, Statistical Note 105, Legal Status of Inpatient Admissions to State and County Mental Hospitals, U.S. 1972, Table 1a (1972). (Hereafter, "Stat. Note 105").

[56] This calculation is based on nationwide data reported in Stat. Note 105, Table Ia, *supra*.

rights accorded to adults. The sole ground on which children are denied a hearing is the consent or acquiescence of a parent or custodian. For several reasons, this is not a constitutionally adequate basis on which to deny the child's evidentiary hearing rights.

1. State Welfare Agencies Should Not Be Permitted to Waive a Child's Evidentiary Hearing Rights

It is important to emphasize at the outset that in many cases there is no parent involved in the decision to commit a child. In these cases, consent for the commitment is provided by the state welfare department, acting as guardian or "standing in loco parentis" to the child.[57] For example, in *Poe* v. *Mathews, supra,* twelve of the forty-eight "voluntary" juvenile patients on hospital rolls as of December 31, 1974 were committed as a result of applications filed by welfare agency officials.[58]. *See also* A. 311; *J.L.* v. *Parham, supra,* 412 F.Supp. at 132-33.

The generally asserted justification for the voluntary scheme—"the rights of parents to direct the upbringing of their children" (Pa. Br. at 30)—obviously does not apply to the commitment of children by state agencies. Welfare departments are not parents. They do not have toward their wards the emotional commitment a parent may be expected to have toward his child, and which may be thought to provide protection against arbitrary decisions. Welfare departments do not live with the children in their custody. They are not

[57] *See* statutes cited in note 5 *supra.*

[58] Defendants' Answer to Plaintiffs' First Interrogatories #26 (k).

knowledgeable as to their history or their emotional needs. They simply perform a placement function.

The court in *J. L.* v. *Parham, supra,* found that mental institutions are often used by state welfare agencies to dispose of difficult children for whom a suitable placement cannot readily be found. *J. L.* v. *Parham, supra,* 412 F.Supp. at 134-35.[59] A case in point is amicus J. R. In 1970, at the age of 7, he was placed in a state mental institution by the Georgia Department of Family and Children Services. *Id.,* at 116. Institutional officials have conceded since 1973 that J. R. does not need to be institutionalized, stating that he "will only regress if he does not get a suitable home placement, and as soon as possible." *Id.,* at 117. But J. R. was not re-

[59] The reasons for this were described by Dr. John P. Filley, Director of the Office of Child and Adolescent Mental Health Services, Atlanta, Georgia:

> The [welfare department] takes the child to the hospital and says, "Now, it's off our hands." They're beseiged with oversized case loads and so on . . . . [T]o take on the tough problem of a kid who's been through a period of hospitalization and is still not normal . . . it's going to take some extra work. And, to take it on at a time when they're already carrying 70 or 80 normal foster care cases is a high requirement on them.

J. L. v. *Parham, supra,* Deposition at 74. *See also Poe* v. *Mathews, supra,* Mess. Aff. at 9-10:

> Social agencies and child care institutions that request mental hospitalization of a juvenile are affected by different but equally significant institutional interests and pressures which can distort their judgment and result in inappropriate requests for hospitalization. The lack of adequate bed space for all those children assigned to the social agency, insufficient staff at particular times of the day or night, a paucity of psychiatric services at the social agency, and the bureaucratic tendency to reject those children who don't immediately conform to the required routines and schedules often culminate in an agency decision to transfer the troublesome or unwanted child to the mental hospital.

leased from the hospital until 1976, after the decision of the district court invalidating the state's commitment procedures.

Whatever rule may be applicable to the decision of natural parents to commit a child, it is clear that a state agency should not be permitted to authorize commitment of a child to a mental institution without the check provided by hearing procedures.

2. Parents Should Not Be Permitted to Waive a Child's Evidentiary Hearing Rights

But even when it is a parent who consents to the commitment, there are strong reasons not to treat this consent as dispensing with the necessity for the careful exploration of the appropriateness of confinement that an evidentiary hearing would allow.

a. *Circumstances Often Prevent Parents From Making an Informed Judgment as to the Suitability of Commitment*

Many parents who consent to commitment do so only because they believe there is no other alternative, not because they are convinced of the child's need for institutionalization. The commitment decision is usually preceded by a series of traumatic episodes which have placed the parents under a great mental strain. *See, e.g.*, A. 570-71, 588-90, 601, 616-17, 733-34. Parents are often unaware of the existence of or are unable to afford other treatment alternatives, such as an outpatient clinic or a private psychiatrist.[60] Thus, when they turn to the public mental institution for assistance and are advised by the institutional psychiatrist that their child needs to be institutionalized, they are in no position to determine otherwise.

[60] *See* Ellis, *supra*, 62 Calif. L. Rev. at 851-52.

The case of amicus Michael K. is illustrative. Michael was committed to Connecticut Valley Hospital under the Connecticut voluntary scheme. His parents consented to his commitment. At a preliminary hearing in *Martin M.* v. *Shepherd, supra,* Michael's father testified:

> Q. During the year Michael was [in the Hospital] did you, as his parent, feel that it was an appropriate place for him to be?
> A. No way, no way.
> Q. Why not?
> A. The conditions were deplorable.
> . . . .
> Q. Why did you sign him in the hospital?
> A. We had no other recourse, none.

Mr. Karl K., T. at 7.

Alternatively, a parental decision to seek commitment may result merely from failure in communication or honest differences in values.

> Parents may be confused, bewildered, and saddened by what they perceive as their child's "crazy" behavior. In individual cases there may be some validity to the parents' belief in a connection between acceptance of counter cultural styles and emotional difficulties, but parents' own visceral reaction to the different lifestyle may color their diagnosis. Where parental action does result in unjustified commitment, it is probably not due to malevolence or filial hatred but to a feeling more akin to irritation or embarrassment over the child's unconventional behavior. The level of irritation or embarrassment can become acute and reach a level where parents become desperate.

Ellis, *supra,* 62 Calif. L. Rev. at 851 (citations omitted); *see* B. Ennis & L. Siegel, The Rights of Mental

PATIENTS 38 (1973); *J. L.* v. *Parham, supra,* Mess. Dep. at 9.

b. *The Interests of the Parent May Not be Consistent With the Interests of the Child*

Statutes which permit a parent to commit a child without a hearing are based on the assumption that a parent will act consistent with his or her perception of the best interests of the child, and normally this will be the case. But, in many instances, as the court below determined, this is not the case.

> In deciding to institutionalize their children, parents . . . may at times be acting against the interests of their children.

A. 797-98.

Virtually every court that has considered the issue has found that with respect to the commitment of a child, there is a potential conflict between the interests of the parents and the interests of the child. *See, e.g., Heryford* v. *Parker,* 396 F.2d 393, 396 (10th Cir. 1968); *J. L.* v. *Parham, supra,* 412 F.Supp. at 133; *Saville* v. *Treadway,* 404 F.Supp. 430, 432 (M.D. Tenn. 1974); *New York Association for Retarded Children* v. *Rockefeller,* 357 F.Supp. 752, 762 (E.D.N.Y. 1973); *Horacek* v. *Exon,* 357 F.Supp. 71, 74 (D. Neb. 1973); *In re Henry G.,* 28 Cal. App. 3d 276, 285, 104 Cal. Rptr. 585, 591 (2nd Dist. 1972); *In re Lewis,* 51 Wash. 2d 193, 200-01, 316 P. 2d 907, 911 (1957); *In re Sippy,* 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953); *In re Wretlind,* 225 Minn. 554, 561-62, 32 N.W. 2d 161, 166-67 (1948).[61]

[61] The Chief Justice has advised of "the need to make civil commitment difficult, recognizing the dangers of relatives 'farming' out their kindred into mental institutions for motives not always worthy." *Kent* v. *United States,* 401 F.2d 408, 416 n.4 (D.C. Cir. 1968) (Burger J., dissenting).

The sources of this potential conflict are varied. In some instances the parent, for one reason or another, simply may not want to live with a difficult child. A case in point is amicus J. L. It was stipulated in the district court in *J. L.* v. *Parham* that this child was hospitalized because his mother was concerned that he was adversely affecting her relationship with her second husband and their child. Stipulation of Fact, Exhibit #2-B-2; Mess. Dep. at 44-46. Following her consent to J. L.'s commitment, she abandoned him and the institution thereafter was forced to deal with the state welfare agency in matters regarding J. L. 412 F.Supp. at 117. J. L. was confined at the Central State Hospital for more than five years, long after the hospital recommended his removal from confinement. *Id.* The district court found that this situation was not unique.

> Unfortunately, as the evidence indicates, there are some parents who abuse [the] authority [to commit] and who under the guise of admitting a child to a mental hospital actually abandon their child to the state. . . . [S]ome still look upon mental hospitals as a "dumping ground."

Id., at 138.

But even when the conflicting interests are not so apparent, the basis for conflict exists. The emotional difficulties of children are almost always the result of a larger, more deep-seated family problem such as marital tension, financial uncertainty, or alcoholism. "Whenever there is a sick child, there is usually a sick family." *Id.,* Deposition of Dr. Wladyslaw Mazur at 9. Indeed, on many occasions it is because of the family's

"disinterest and inability to get along that the child gets sick." *Id.,* Deposition of Dr. James Craig at 11.

By focusing on the apparent pathology of the child, parents may be able to obscure the underlying problems and preserve the equilibrium of the family unit. A. 467-68, 471-72, 501, 588-89, 610, 668-69, 734.[62] This phenomenon is known as "scapegoating."

> From the point of view of the family, the primary function of scapegoating is that it permits the family to maintain its solidarity. . . . By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes. There seemed to be an added solidarity between the parents who stood united against the problem child. The fact that it is a child who is disturbed permits the parents to continue to perform the tasks necessary for household maintenance.

Vogel and Bell, *The Emotionally Disturbed Child as the Family Scapegoat,* in A MODERN INTRODUCTION TO THE FAMILY 425 (rev. ed. 1968).

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[62] The decision to inquire about psychiatric help is always the outcome, to some degree, of a crisis in the family. . . . [The parents] may define the problem in terms of the child because they sense he threatens their psychic stability and their control over their anger. . . . They may suspect that it is they who need psychiatric help but come to get help for the child since he is the focal point of disturbance; he absorbs and reflects the conflicts in themselves.

THE MENNINGER FOUNDATION CHILDREN'S DIVISION, DISTURBED CHILDREN: EXAMINATION AND ASSESSMENT THROUGH TEAM PROCESS 23-24 (1969). *See* LAING AND ESTERSON, SANITY, MADNESS AND THE FAMILY (1964); Ellis, *supra,* at 860, 863; T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 153-54 (1963); Chassen, Perelman and Weinberger, *Reducing Parental Resistance to Examination of Family Relationships: The Therapeutic Use of a Child Management Task,* 11 PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE 387 (Winter 1974).

c. *Parents Have Not Been Permitted Absolute Control Over The Rights of Their Children*

Last Term, in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. ——, 44 U.S.L.W. 5197 (July 1, 1976), this Court held that a parent may not be granted an absolute veto over the decision of a minor child to secure an abortion. Perhaps even more significant to the decision in the instant case, in *Bellotti* v. *Baird,* 428 U.S. ——, 44 U.S.L.W. 5221 (July 1, 1976), the Court strongly indicated that a statute that permitted a child to obtain judicial approval for an abortion, where parental approval was withheld, would pass constitutional muster. Thus, the Court refused to uphold absolute parental control over a decision vital to the life of a minor, but implied that where there was disagreement, it could be properly resolved through a hearing procedure. That is exactly the result sought by plaintiffs here, in the context of a proposed civil commitment.

The decisions in *Danforth* and *Bellotti* are consistent with the historic rule that parents do not have unrestricted authority over the lives of their children. *See generally* 1 W. BLACKSTONE, COMMENTARIES *452-53, 460-66; 3 J. STORY, COMMENTARIES ON EQUITY JURISPRUDENCE, Chapter 34 (1835); J. WOERNER, A TREATISE ON THE AMERICAN LAW OF GUARDIANSHIP OF MINORS AND PERSONS OF UNSOUND MIND § 14 (1897). The law has long recognized that when the interests of children might conflict with those of their parents, independent representation for the children is required. *See, e.g., Prince* v. *Clark,* 81 Mich. 167, 170-71 (1890). Thus, courts have frequently appointed independent guardians for children and have refused to allow parents to

donate their children's organs;[63] alienate their children's property;[64] compromise their children's injury claims;[65] withhold non-essential medical treatment from their children;[66] and authorize the sterilization of their children.[67]

In *Prince* v. *Massachusetts,* 321 U.S 158 (1944), this Court pointed out that although "the custody, care and nurture of the child reside first in the parents," parental rights are not "beyond limitation." 321 U.S. at 166. Given the possibility for error and for basic conflicts of interests, this Court should not permit a parent to foreclose a child's right to be heard in connection with a decision as crucial to his life as commitment to a mental institution.

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[63] *See, e.g., In re Guardianship of Pescinski,* 67 Wis. 2d 4, 226 N.W. 2d 180 (1975); *Hart* v. *Brown,* 29 Conn. Sup. 368, 289 A. 2d 386 (1972); *Strunk* v. *Strunk,* 445 S. W. 2d 145 (Ky. 1969); *In re Richardson,* 284 So. 2d 185 (La. App.), *cert. denied,* 284 So. 2d 338 (S.Ct.La.1973).

[64] *See generally* 1 W. BLACKSTONE, COMMENTARIES *452-53, 465-66; 4 KENT, COMMENTARIES ON AMERICAN LAW 185-89 (1830); *see, e.g., Martorell* v. *Ochoa,* 276 F.99 (1st Cir. 1921); *In re Schulz Estate,* 374 Pa. 459, 98 A.2d 176 (1953).

[65] *See, e.g., American Mutual Liability Insurance Co.* v. *Volpe,* 284 F.75 (3rd Cir. 1922); *White* v. *Osborne,* 251 N.C. 56, 110 S.E. 2d 449 (1959); *Loesch* v. *Vassiliades,* 17 N.J. Super. 306, 86 A. 2d 14 (1952).

[66] *See, e.g., Jacobson* v. *Massachusetts,* 197 U.S. 11 (1944); *Green Appeal,* 448 Pa. 338, 292 A.2d 387 (1972), *appeal after remand,* 452 Pa. 373, 307 A.2d 658 (1973); *Re Sampson,* 65 Misc. 2d 658, 217 N.Y. S.2d 641 (Fam. Ct.), *aff'd,* 37 A.D. 2d 668, 323 N.Y.S. 2d 686 (1972); *Re Carstairs,* 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952).

[67] *See, e.g., A.L.* v. *G.R.H.,* 325 N.E. 2d 501 (Ct. App. Ind. 1975); *In re NK.R.,* 515 S.W. 2d 470 (Mo. 1974); *Frazier* v. *Levi,* 440 S.W. 2d 393 (Civ. App. Tex. 1969).

It has been argued that hearings will disrupt the family relationship, but to paraphrase the words of this Court in *Danforth,* "[i]t is difficult . . . to conclude that providing a parent with absolute power" to commit a child to a mental institution over his objection "will serve to strengthen the family unit. Neither is it likely that such . . . power will enhance parental authority or control where the minor and the . . . parent are so fundamentally in conflict" and the parental effort to commit "already has fractured the family structure." 428 U.S. ——, 44 U.S.L.W. 5197, 5204 (July 1, 1976).

Indeed there is a substantial basis for the belief that affording a child a hearing right, where he disagrees with his parents' commitment decision, will enable parent and child to confront their differences openly, and may lessen the already existing conflict.

> This effort at fact finding itself would have a therapeutic effect on the child and family; for some it would be the first time they will have been exposed to all sides of the story. The end result would be to greatly reduce the trauma suffered by juveniles who are rushed through the present [procedure].

Poe v. *Mathews, supra,* Mess. Aff. at 14. *See also* E. GOFFMAN, ASYLUMS 140-41 (1961); *cf. In re Gault, supra,* 387 U.S. at 26; *In re Ballay, supra,* 482 F. 2d at 664.

CONCLUSION

The judgment of the court below should be vacated, and the case dismissed as moot and for lack of standing. Alternatively, the case should be remanded to the district court for reconsideration in light of the changes in Pennsylvania law.

If the Court reaches the merits of this appeal, its decision should recognize the right of a child to counsel and an evidentiary hearing in connection with civil commitment sought by a parent or custodian.

Respectfully submitted,

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